

MedStart-5

Application for Assistance

Transportation

Meals Assistance

Utilities

Co-Payments

Adult Home Care

Lab Testing

For application help, contact us at

1-888-842-2654

Instructions

To apply for benefits, follow these easy steps:

1. Complete the Application

Complete the **entire** four pages of the application. If not, this will slow down the application process. Please be accurate. If you are applying for someone else, answer the questions as they relate to that person.

2. Submit the Application

Once you have completed the application mail or fax the original. If you fax the application, **the original physician letter must be received before the application can be approved**. The date your application will start is based on the date it is received by No Wooden Nickels.

3. Supporting Documentation

Check the table below to see what proof is required for the programs you are applying for. Include copies (or originals, if requested).

5. Equal Opportunity

This application will be considered without regard to race, color, gender, age, disability, religion, national origin, or political belief.

6. Questions?

If you need assistance with this application or have any questions, contact No Wooden Nickels by calling 1-888-842-2654. Applications are also available on our website at www.nowoodennickels.org/programs.html

FAQS

Do I Have to Be a Citizen?

No. However, you must have a valid social security card, work visa, Medicaid or Medicare insurance in order to apply.

How Soon Will I Receive Assistance?

This depends on how soon you complete and return your application however, once the initial interview is complete and depending on the type of assistance you request, assistance can begin within 2 days up to 3 weeks.

Can I Complete the Application for Someone Else?

Yes. A photo ID must accompany the application along with your signature.

Which Vendors Will Provide These Services?

We work with a list of vendors to provide a number of services for transportation, meals, medical equipment, etc. However, if there is a vendor which you would prefer to use, have them contact our office at 888-842-2654 to explore contracting services with that vendor.

Where Do I Send The Completed Application?

Mail or fax the completed application to the following address:

**No Wooden Nickels
Patient Services
P.O. Box 5287
Evanston, IL 60204
(Fax) 847-864-4314**

DISCLAIMER

Please note the following regarding the MedStart-5 application process:

1. No Wooden Nickels makes no guarantees of approval of an award due to the completion and submission of an application.
2. No Wooden Nickels requests supporting documentation to substantiate patient expense requests for assistance but does not guarantee that submission of any documentation constitute an agreement to payment of all submitted invoices/statements or services.
3. No Wooden Nickels maximum award amounts are determined at its annual Board of Directors meeting at the end of its fiscal year (December 31st) and disclosed in its documentation and website by January 30th of the following year. The maximum amount may also change at any given time throughout the year. **For year 2010 the maximum award amount will not exceed \$350 per application.**
4. The maximum award amount is an indication that a recipient **may receive** up to the maximum award amount set each year but does not guarantee the maximum in any circumstance. It is the sole discretion of NWN the amount of an award for any expenses.
5. No Wooden Nickels process applications on a case-by-case basis. Some of the factors considered in determining award amounts include monthly income, number of household members and overall expenses.
6. By signing a completed application you have agreed that you understand that the MedStart-5 program and it's accompanying programs provide assistance for **low-income cancer** patients. Although decisions on awards are based on many factors, please consider the federal poverty chart as a possible measure.
7. Due to current HIPPA laws No Wooden Nickels is not always able to verify balances with a creditor. Since we are not the patient many creditors will not speak with our staff regarding some of the simplest inquiries, such as outstanding balances. We may attempt to verify the balance electronically using information which you provided. If a statement or invoice is greater than 30 days, we MUST verify the balance with the creditor only if they are willing to reveal such information. If we are unable to verify a current balance, we may then seek other expenses where we may be able to assist. If enough information is provided within the patient application, we proceed with processing those expenses. If not, we will make every attempt to contact the applicant.
8. Please note that you are within your right to close your application at any time prior to a final decision and not accept assistance.
9. Denial of an award is not taken lightly therefore guidelines that govern a denial are some of the following: a)fraudulent application; b)misrepresentation of income; c)patients who are not in active treatment—the application process must begin before treatment has ended; d)denial can also occur at any time during the application process if it is discovered that an applicant, his/her authorized representative (including social workers, patient navigators or other health official) has conducted him or herself in an inappropriate manner or exhibited inappropriate behavior to any staff member or volunteer; and e)if after receiving a “supporting documentation letter” from NWN, the patient did not return all requested supporting documentation or failed to call for an extension within the timeframe stated within the SDL.

Supporting Documentation

If You Are Applying for	You MUST Include
<div style="border: 2px solid red; border-radius: 50%; width: 100px; height: 100px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> <p style="margin: 0;">All Requests</p> </div>	<p>1) <u>A Letter from Your Physician</u></p> <ul style="list-style-type: none"> ❖ The letter <u>MUST BE TYPED ON ORIGINAL LETTERHEAD.</u> No Exceptions. ❖ The letterhead must come from your physician, hospital or treatment facility and show the street address, telephone number and signed by your physician. ❖ If your original diagnosis occurred more than 6 months prior to your application, you must submit a new letter. ❖ Diagnosis on a script pad is <u>not acceptable.</u> ❖ The letterhead must state the following: <ul style="list-style-type: none"> ▶ Current diagnosis ▶ Course of treatment ▶ Length of treatment <p>2) <u>Proof of Income</u></p> <ul style="list-style-type: none"> ❖ Income must be established before your application can be processed. ❖ Check stubs for the past 30 days to run concurrent. ❖ If you're receiving or have applied for Social Security, Disability, etc., a copy of the letter of application or award letter must be included. ❖ Unless you are self-employed DO NOT SUBMIT tax returns. They will not be returned to you. <p>3) <u>Copies of Statements/Invoices for which you Seek Assistance</u></p> <ul style="list-style-type: none"> ❖ Only submit copies of statements for which you are seeking assistance unless requested. (e.g, if you seek assistance with insurance premiums, a stub, invoice or statement with address must accompany your application). ❖ If you do not include copies of statemtents/invoices <u>your request will not be considered.</u> ❖ Do not submit originals unless requested as all non-compliant items will not be returned.
<div style="background-color: #ffff00; padding: 5px; writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold;">IF YOU NEED HELP WITH</div> <ul style="list-style-type: none"> → Lab Testing → Co-Payments → Insurance Premiums → Outstanding Medical Bills → Special Equipment or Clothing → Transportation (Gas) → Parking → Meals During Treatment → Telephone → Electric/Water → Gas → Special Meals (at home) → Adult In-Home Care → Child Care During Treatment 	<p>Copies of statements/invoices.</p> <p>Make sure all billing/contact information is available on all statements/invoices.</p> <p>Original receipts submitted by mail</p> <p>Will only be considered in cases of pending or current interruption of services</p> <p>If currently receiving, proof of providing agency and/or statement.</p> <p>Proof of attendance and/or statement from child care provider</p>

YOU MUST INCLUDE

CASE #: _____
 ASSIGNED TO: _____

Application for Assistance

First Name	Middle Initial	Last Name	Maiden Name (if applicable)
Home Address	City	State	Zip
Mailing Address (if different from above)			
Daytime Phone Number	Cell Number	Email Address	
Gender:	_____ Male	_____ Female	
How Did You Hear About Us? _____			

I am applying to receive the following assistance: (WE DO NOT PROVIDE MORTGAGE/RENT ASSISTANCE)

Medical Expenses Assistance

- | | |
|--|---|
| <input type="checkbox"/> Lab testing | <input type="checkbox"/> Insurance Premiums |
| <input type="checkbox"/> Co-Payments | <input type="checkbox"/> Doctors Visit |
| <input type="checkbox"/> Outstanding Bills | <input type="checkbox"/> Medication |

Transportation Assistance

- | | |
|---|----------------------------------|
| <input type="checkbox"/> To/From Treatment Facility | <input type="checkbox"/> Parking |
|---|----------------------------------|

Utilities Assistance*

- | | |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Telephone | <input type="checkbox"/> Electric |
| <input type="checkbox"/> Water | <input type="checkbox"/> Gas |

Meals Assistance

- | | |
|---|--|
| <input type="checkbox"/> Meals During Treatment | <input type="checkbox"/> Special Meals (at home) |
|---|--|

Other Services

- | | |
|---|--|
| <input type="checkbox"/> Adult In-Home Care | <input type="checkbox"/> Child Day Care |
| If you need child or adult care assistance, do you currently have a child/adult care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Special Clothing | <input type="checkbox"/> Medical Equipment or Supplies |
| <input type="checkbox"/> Scholarship (Must first be approved through MedStart-5) | |

* Only in cases of pending interruption of services

To make sure you receive all the help you qualify for, answer the following questions by checking yes or no and include additional information where requested. Empty spaces will delay the application process.

Are you currently employed?

Yes No

If no, when was the last day/date you worked _____

Do you currently have medical insurance?

Yes No

If so, please provide name of insurer _____

Is anyone in your household including you receiving or have applied for Disability?

Yes No

Is anyone in your household including you receiving or applying/applied for Social Security?

Yes No

Do any children in your home have a parent not living with them?

Yes No

Are you or any children in your household (or which you provide support), currently attending grade school, high school, a college or university?

Yes No

If so, what year of study are you/the student currently in _____

How many people currently reside in your household? _____

What is your current marital status? Married Divorced Single Separated Widowed

Personal/Authorized Representative: You may authorize someone else to apply for benefits for you. If you want to authorize someone, include name, signature and phone of authorized representative to indicate your approval and then sign your name. A copy of the AR's photo ID must be included.

Name of Authorized Representative

Signature of Authorized Representative

Applicant Signature

Phone Number

NOTE: Your signature also indicates that if your authorized representative provides incorrect information that causes us to give you benefits you are not entitled to receive, you may have to repay the benefits to No Wooden Nickels.

Please list each person who lives in your home **including yourself**. Include any unborn children and due date.

NAME	RELATION (spouse, child, stepchild)	DATE OF BIRTH	SEX
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

Household Income: List money received and/or expected for this month. For wages we will need stubs from the last 30 days if you are employed, or previous years federal income tax records if you are self-employed.

Wages (We require your **GROSS** income (income before deductions) and your **NET** income (the amount you take home).

_____	_____
GROSS income	NET income

Please provide copies of last two payments for any of the items below. If you have recently applied for Disability or Social Security, please provide copies of letter showing that you have applied, pending status or denied.

Self-employment	\$ _____	Disability Payments	\$ _____
Unemployment Benefits	\$ _____	Social Security	\$ _____

Ethnicity and Race Definitions Information

Completion of this section of the Application for Assistance (AFA) is **required**. Your selection of race and ethnicity **will not affect your eligibility** for benefits or your benefit amounts. This information is being collected to assure that program benefits are distributed without regard to race, color, or national origin. For the purposes of this section, "Hispanic or Latino" is considered an ethnicity, not a race. **Please answer both ethnicity and race questions for each person.**

Hispanic or Latino

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Ethnicity

Race

Native American Indian or Alaska Native

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Ethnicity**Race**

Black or African American

A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Pacific Islander

A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Caucasian (White)

A person having origins in any of the original peoples of Europe.

I understand that . . .

- • **Knowingly providing false information or withholding information may result in criminal, civil or administrative action (including denial of benefits or required repayment of benefits).**
- • **My signature (or the signature of my representative) authorizes No Wooden Nickels to determine if I am eligible for benefits.**
- • **My signature below certifies that the citizenship/immigration status is correct for each person applying.**

I, _____, swear that the information given on this form is true and correct.

Signature of Applicant/Authorized Representative

Date